



Changes apply to:  
 Medical Only  
 Dental Only  
 Medical and Dental

# MEDICAL & DENTAL CHANGE FORM

PLEASE PRINT

Social Security #	Medical Member #	Dental Member #
Employee Name	Employer Name	Employee Division

### NAME OR ADDRESS CHANGES

Name		Telephone #
Address		City
State	Zip Code	Email Address

### REASON & EFFECTIVE DATE OF CHANGE

Employee Coverage End Date _____	Reason _____
Employee/Spouse/Dependent Change	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____
Comments:	
<b>Please attach documentation such as court documents, Certificate of Creditable Coverage, etc.</b>	

**List eligible Dependents to be covered/terminated, oldest to youngest.** A Dependent is a person who is: 1) the Subscriber's legal spouse; 2) a child of the Subscriber who is a son, daughter or step-child or a child subject to legal guardianship regardless of support level; 3) a grandchild or other blood relative of the Subscriber who depends on the Subscriber for more than 50% of total support; 4) a child of the Subscriber who is recognized under a QMCSO as having a right to enroll under the Contract. List last name if different from employee.

Dependent Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: MALE FEMALE

Dependent Address \_\_\_\_\_

**Medical:**  Add  Delete Effective Date \_\_\_\_\_ **Dental:**  Add  Delete Effective Date \_\_\_\_\_

Dependent Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: MALE FEMALE

Dependent Address \_\_\_\_\_

**Medical:**  Add  Delete Effective Date \_\_\_\_\_ **Dental:**  Add  Delete Effective Date \_\_\_\_\_

Dependent Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: MALE FEMALE

Dependent Address \_\_\_\_\_

**Medical:**  Add  Delete Effective Date \_\_\_\_\_ **Dental:**  Add  Delete Effective Date \_\_\_\_\_

<b>COORDINATION OF BENEFITS INFORMATION:</b>	Have you ever been a PHP member? <input type="checkbox"/> Y <input type="checkbox"/> N
On the date that Coverage is to be effective, will you or your Dependent(s) have any other Coverage? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, complete the following:
Health Plan Name _____	Policy/Group/ID # _____
Dental Plan Name _____	Policy/Group/ID # _____
Claims Address/Phone # _____	Effective Date _____ Termination Date _____
Policyholder's Name _____	Policyholder's Social Security # _____
Covered Individuals _____	Policyholder's Birth Date _____
Employer through which coverage is held _____	<input type="checkbox"/> Medicare Plan A (Hospital only) <input type="checkbox"/> A & B (Hospital & Medical)

**I (WE) HEREBY REPRESENT** that all statements and answers herein are full, complete and true. These statements and answers are to be considered as the basis for Coverage under the Plan. I understand that (1) this form constitutes a part of the Plan Contract and (2) no Coverage will be effective until the date specified by the Plan.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EMPLOYER SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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